1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

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PURPOSE

This policy outlines the administrative requirements of the Division's Medical Management.

DEFINITIONS

1. "Care Management" means a group of activities performed by the Division to identify and manage clinical interventions or alternative treatments for identified Members to reduce risk, cost, and help achieve better health care outcomes. Care Management does not include the day-to-day duties of service delivery.
2. "Corrective Action Plan" or "CAP" means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions or tasks to be taken to facilitate an expedient

return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Division and its Providers, to enhance Quality Management and Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

3. "Division" means the Division of Developmental Disabilities.
4. "Grievance" means a complaint that the Member communicates to the Division.
5. "Health Care Decision Maker" or "HCDM" means an individual who is authorized to make health care treatment decisions for a Member. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in A.R.S. §§ Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8514.05, 36-3221, 36-3231 or 36-3281.
6. "Integrated Systems of Care" or "ISOC" means the coordination of physical and behavioral health care within the AHCCCS health

care delivery system to ensure appropriate, adequate, and timely services for all Members.

7. "Inter-Rater Reliability" or "IRR" means the process of Monitoring and evaluating qualified healthcare professional staff's level of consistency with decision making and adherence to clinical review criteria and standards.
8. "Medical Management" or "MM" means an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the Continuum of Care (CoC) from prevention to hospice.
9. "Medical Management Committee" or "MM Committee" means a Division governing body responsible for MM functions and responsibilities. The MM Committee membership includes:
    a. The Division's Medical Officer or designated Medical Director as the chairperson of the committee;
    b. Division staff focused on Integrated Systems of Care (ISOC);
    c. The Division's MM/Utilization Manager; and

d. Representatives from the functional areas within the Division.

10. "Medical Management Evaluation" or "MM Evaluation" means an annual written narrative assessment summary of the Division's previous year's MM Work Plan.
11. "Medical Management Program Plan" or "MM Program Plan" means the annual written narrative that describes the Division's planned methodology to meet or exceed the MM standards and requirements as specified in the AHCCCS Contract and in the policies found within AMPM Chapter 1000. The MM Program Plan includes the MM Evaluation and MM Work Plan.
12. "Medical Management Work Plan" or "MM Work Plan" means a description of the Division's goals, strategies, activities, and methodology for improvement using the Plan, Do, Study, Act (PDSA) Method, and Monitoring efforts related to the MM Program requirements specified in policies within AMPM Chapter 1000 and AMPM 1010 Attachment B Work PLan Guide and Template.

13. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
14. "Monitoring" means the process of auditing, observing, evaluating, analyzing, conducting follow-up activities, and documenting results.
15. "Plan, Do, Study, Act (PDSA) Method" means a four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.
16. "Prior Authorization" means the approval from a health plan required before a Member receives a service. This is not a promise that the health plan will cover the cost of the service.
17. "Provider" means any individual or entity contracted with the Division that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State.
18. "Quality Management" or "QM" means the evaluation and assessment of Member care and services to ensure adherence to

standards of care and appropriateness of services and can be assessed at a Member, Provider, or population level.

POLICY

A. MEDICAL MANAGEMENT (MM) PROGRAM PLAN

1. The Division shall develop a written MM Program Plan that:
   a. Details how program activities ensure the appropriate management of physical and behavioral health service delivery for enrolled Members;
   b. Meets the required elements listed in AMPM 1010, Attachment A - Medical Program Plan Checklist;
   c. Includes the MM Work Plan and MM Evaluation; and
   d. Includes the signature for the Division's Chief Medical Officer or designated Medical Director and approval date.
2. The Division shall submit the MM Program Plan annually, and any subsequent modifications, to AHCCCS for review and approval prior to implementation.
3. The Division shall include the following components in the MM Program Plan:

a. A description of the Division's administrative structure for oversight of its MM Program Plan, including the role and responsibilities of the following:
    i. The governing or policy-making body;
    ii. The MM Committee;
    iii. The Division Executive Management; and
    iv. Required MM program staff.
b. An organizational chart that delineates the reporting channels for MM activities and the relationship to the Chief Medical Officer, unless delegated to an associate Medical Director and Executive Management.
c. Documentation that the Division's governing or policy-making body has reviewed and approved the MM Program Plan.
d. Documentation that qualified, trained, and experienced personnel are employed by the Division to effectively carry out MM program functions.
e. The Division's specific MM goals and measurable objectives as required by AHCCCS policy.

f. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to Members in compliance with state and federal regulations:

   i. MM Utilization Data Analysis and Data Management;

   ii. Concurrent Review;

   iii. Discharge Planning;

   iv. Prior Authorization;

   v. Inter-Rater Reliability;

   vi. Retrospective Review;

   vii. Clinical Practice Guidelines;

   vii. New Medical Technologies and New Uses of Existing Technologies;

   ix. Case Management/Care Coordination;

   x. Disease/Chronic Care Management; and

   xi. Drug Utilization Review.

g. The Division's method(s) for Monitoring and evaluating its service delivery system and Provider network that demonstrates compliance with AHCCCS policy.

h. A description of how delegated activities are integrated into the overall MM Program and the methodologies for oversight and accountability of all delegated functions, as required by AHCCCS policy.

i. Documentation of input into the medical coverage policies from the Division or Providers and Members.

j. A summary of the oversight and Monitoring of changes made to the AdSS' list of services requiring Prior Authorization and the rationale for those changes.

B. MM WORK PLAN

1. As part of the MM Program Plan, the Division shall develop a MM Work Plan that meets the following requirements:

   a. Is submitted using the format on the AMPM 1010 Attachment B - Work Plan Guide and Template;

   b. Supports the MM Program Plan goals and objectives;

   c. Includes goals that are quantifiable and attainable;

   d. Includes specific actions for improvement; and

e. Incorporates a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area.

2. The Division shall follow the requirements in AMPM 970 for PDSA methodologies.

C. MM EVALUATION

1. As part of the MM Program Plan, the Division shall:
   a. Develop a written MM Evaluation of the effectiveness of the previous year's MM Work Plan;
   b. Obtain review and approval of the MM Evaluation from the Division's governing or policy-making body; and
   c. Submit the MM Evaluation to AHCCCS after being reviewed and approved by the Division's governing or policy-making body.
2. The Division shall include the following information in the MM Evaluation of the previous year's MM Work Plan:
   a. A summary of the MM activities performed throughout the year with the following:
      i. Title or name of each MM activity;

ii. Established goal and objective(s) related to each MM activity;

iii. Description of the Division's staff positions with role and responsibility of involvement in MM activities;

iv. Trends identified and the resulting actions implemented for improvement;

v. Rationale for actions taken or changes made; and

vi. A statement describing whether the goals or objectives were met.

b. Review, evaluation, and approval by the Division's MM Committee of any changes to the MM Program Plan and MM Work Plan.

D. MM ADMINISTRATIVE OVERSIGHT

1. The Division shall require ongoing communication and collaboration between the Division MM Committee and other functional areas of the Division to include:

a. Quality Management (QM);

b. Member services; and

c. Network services.

2. The Division shall have an identifiable and structured MM Committee that is responsible for MM functions and responsibilities.
3. The Division shall require that MM Committee meeting agenda items and minutes reflect the presentation, discussion, and actions on MM issues and topics, if the MM Committee is combined with the Division's QM Committee.
4. The Division shall require the Chief Medical Officer, as chairperson for the MM Committee, or the chairperson's designee, to be responsible for:
    a. Implementation of the MM Program Plan, MM Work Plan, and MM Evaluation; and
    b. Involvement in the assessment and improvement of MM activities.
5. The Division shall require the Division staff focused on Integrated Systems of Care (ISOC) to be responsible for involvement in the healthcare aspects of the MM Program.
6. The Division shall require the MM Committee to:

a. Follow requirements related to confidentiality and conflicts of interest with signed statements from MM Committee members on file; and

b. Document MM Committee member attendance in committee meeting minutes with confidentiality and conflicts of interest requirements noted.

7. The MM Committee shall meet at least quarterly to monitor all findings and required actions.

8. The MM Committee shall include the following information in meeting minutes:

   a. Data reported to the MM Committee;

   b. Analysis and recommendations made by the MM Committee;

   c. If noted in the MM Committee meeting minutes, data may be attached to the MM Committee meeting minutes as separate documents.

9. The MM Committee shall make and discuss recommendations at MM Committee meetings.

10. The MM Committee shall review and update MM program objectives and policies annually and when necessary by:
    a. Documenting MM responsibilities for each MM function and activity;
    b. Informing Division staff, of current MM requirements, policies, and procedures to allow for implementation that does not adversely impact Members; and
    c. Providing MM policies and procedures, and any subsequent modifications upon request to AHCCCS.
11. The Division shall staff the MM Committee with a sufficient number of qualified personnel to carry out MM functions and responsibilities.
12. The Division shall develop staff requirements for education, experience, and training for each MM position.
13. The Division shall maintain a current organizational chart to show reporting channels and responsibilities of MM staff.
14. The Division shall maintain and make available to AHCCCS upon request records that document MM activities. The required documentation includes, but is not limited to:

a. Policies and procedures;

b. Reports;

c. Practice guidelines;

d. Meeting minutes including analyses, conclusions, and actions required with completion dates;

e. Corrective Action Plans resulting from the evaluation of any component of the MM program; and

f. Other information and data deemed appropriate to support changes made to the scope of the MM Program Plan.

15. The Division shall have written policies and procedures that require:

a. Verification that information and data received from the AdSS is accurate, timely, and complete;

b. Review of reported data for accuracy, completeness, logic, and consistency;

c. Documentation of the processes used for reviewing and evaluating reported data;

d. Security and confidentiality of all Member and Provider information protected by Federal and State law;

f. Identification of Provider trends and subsequent necessary corrective action regarding over or under utilization of services; and

g. Annual evaluation and updates to the MM Program Plan.

E. REQUIREMENTS FOR HEALTHCARE PROFESSIONALS AND HEALTH CARE SERVICE DECISIONS

1. The Division, as specified in 42 § C.F.R. 457.1230(d) and 42 § C.F.R. 438.210(b)(3), shall require qualified health care professionals, with appropriate clinical expertise in treating the Member's condition or disease, to render decisions to:
   a. Deny an authorization request based on medical necessity;
   b. Authorize a request in an amount, duration, or scope that is less than requested; or
   c. Make a decision involving excluded or limited services under A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in this policy.
2. The Division, as specified in 42 C.F.R. § 457.1260 and 42 § C.F.R. 438.406(b)(2), shall require qualified health care professionals, with appropriate clinical expertise in treating the

Member's condition or disease, and who have not been involved in any previous level of decision making, to render decisions regarding the following:

a. Appeals involving denials based on medical necessity;

b. Grievances regarding denial of expedited resolution of an appeal; and

c. Grievances and appeals involving clinical issues.

3. The Division shall require qualified health care professionals to have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and non-skilled services within their scope of practice.

4. The Division shall have written job descriptions with qualifications for the following qualified health care professionals who render decisions or review denials:

a. Physician;

b. Podiatrist;

c. Optometrist;

d. Chiropractor;

e. Psychologist;

f. Dentist;

g. Physician assistant;

h. Physical or occupational therapist;

i. Speech-language pathologist;

j. Audiologist;

k. Registered or practical nurse, to include:

i. Nurse practitioner;

ii. Clinical nurse specialist;

iii. Certified registered nurse anesthetist; and

iv. Certified nurse midwife.

l. Licensed social worker;

m. Registered respiratory therapist;

n. Licensed marriage and family therapist; and

o. Licensed professional counselor.

5. The Division shall, as specified in AMPM Chapter 1600, have ALTCS case management staff with the appropriate clinical expertise to render decisions for the following non-skilled Home and Community Based Services, to include:

a. Attendant care,

b. Personal care,

c. Homemaker,

d. Habilitation, and

e. Non-nursing respite.

6. The Division shall make determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

7. The Division shall, when making medical necessity determinations:

a. Use the assistance of a board-certified consultant; and

b. Document evidence of working with a board-certified consultant.

8. The Division shall apply consistent standards, clinical criteria, and decisions that include:

a. Inter-Rater Reliability (IRR) criteria;

b. Monitoring of all staff involved in the Prior Authorization or

concurrent review process; and

c. A plan of action developed and implemented for staff who fail to meet the IRR standards of 90%.

9. The Division shall notify the following individuals, as applicable, of any decision to deny, limit, or discontinue authorization of services at least 10 days before the date of the action:

a. The requesting Provider; and

b. The Member; or

c. Member's authorized representative; or

d. Medical power of attorney.

10. The Division shall include the required information specified in ACOM 414 and 9 A.A.C. 34 in the notice to deny, limit, or discontinue authorization of services.

11. The Division shall provide access to staff for Members and Providers seeking information about the MM process and service authorizations.

F. HEALTH INFORMATION SYSTEM REQUIREMENTS

The Division shall maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program with data elements to include:

a. Member demographics;

b. Services provided to Members; and

c. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

G. DIVISION OVERSIGHT OF DELEGATED MM FUNCTIONS

1. The Division shall obtain prior approval from AHCCCS to delegate a portion of Care Management functions to an Administrative Services Subcontractor (AdSS).

2. The Division shall oversee and maintain accountabilities for all MM functions or responsibilities that are delegated to other entities.

3. The Division shall keep documentation for AHCCCS review that demonstrates the following requirements are met for all delegated functions:

    a. An executed written agreement that:

        i. Specifies the delegated MM activities and reporting responsibilities of the AdSS to the Division; and

        ii. Includes provisions for revocation of the delegation or imposition of sanctions for inadequate performance.

    b. The Division's evaluation of the AdSS's ability to perform the delegated activities prior to executing a written agreement for delegation.

H. COMPENSATION AND ADVOCACY FOR SERVICE PROVISION

The Division shall monitor the AdSS to ensure the following:

a. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to

provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.

b. Providers are not prohibited from advocating on behalf of Members within the service provision process.

I. DIVISION OVERSIGHT AND MONITORING

The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

a. Annual operational review of each AdSS;

b. Review and analysis of deliverable reports submitted by the AdSS; and

c. Conducting oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance;

ii. Addressing concerns with access to care or other quality of care concerns;

iii. Discussing systemic issues; and

iv. Providing direction or support to the AdSS as necessary.

Signature of Chief Medical Officer: Anthony Dekker (Nov 8, 2024 17:18 MST)
Anthony Dekker, D.O.